

**DISTRICT OF COLUMBIA HEALTH BENEFIT EXCHANGE AUTHORITY
PRODUCER ADVISORY COMMITTEE**

CANDIDATE APPLICATION

DATE: _____

CANDIDATE NAME: _____

ADDRESS: _____

DAYTIME PHONE: _____ **E-MAIL ADDRESS:** _____

Please answer the following questions:

1. Are you a resident of/or have a principal place of business in the District of Columbia? Yes No
If no, which state? _____
2. What is your current occupation? _____
If agent or broker, are you a DC Health Link certified broker? Yes No
If DC Health Link certified broker, which markets do you serve? Individual SHOP (small business)
3. Name of Employer (if you will be representing your employer on the committee)? _____
4. Check any that apply:
 - Health professional;
 - Health insurance consumer;
 - Disease and demographic-specific advocacy groups;
 - Commercial sector health plans;
 - Public sector health plans;
 - Health insurance brokers;
 - Health care consumer interest advocacy;
 - Health care foundations;
 - Exchange consumer
 - Such other interests considered necessary, list: _____
5. List any diversity characteristics such as ethnicity, language skills, etc. (optional).

6. Are you presently a member of any other board, committee, or commission in the District of Columbia government? If yes, please state the names of the board, committee, or commission, and your length of service. _____

By signing below, you attest that all the information above is true and that you will make all efforts to be present at every meeting of the Producer Advisory Committee. HBX retains the right to remove members due to lack of participation.

Signature

Date